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Original Lectures.

CEREBRAL SYPHILIS.

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The following is a synopsis of several talks to the Hahnemann students at different periods of development in this more than usually interesting case. It served us as a study in various lines of cerebral pathology. Brain tumor, localization, cerebral hæmorrhage, thrombosis and embolism, syphilitic gumma and meningitis, as well as the ocular changes in intracranial disease, were not only differentiated, but in large measure exemplified by the lesions in this one individual.

History. William H., colored, aged thirty-seven years. About Thanksgiving time, 1895, he experienced the first sickness in twelve years. Was treated for diabetes at Waukesha. Reports full recovery. His present illness dates from that time. It began with the symptoms of a severe cold, frontal headache and cough. These symptoms continued unchanged until April, 1896, when deafness of the right ear appeared, accompanied by marked weakness of the lower limbs from the knees down, associated with occasional slight pain. During the first week in July, the muscular debility was still more marked, and the pains were more severe. In this month, he suffered also from excruciating frontal headache, lasting two to three weeks.

In August, while sitting in a dark room, a light was brought in, when suddenly he felt blindness invade the

right eye. Since then the eyeball and lid have remained immobile, and the eye has continuously increased in size and hardness. From that time on the pains have been confined mostly to the right side of the head, and the sense of hearing of the right ear has remained impaired.

He entered the Hahnemann Hospital August 26, and for a period of almost five months, he was under the surveillance of the staff and received the care of that institution. More than once he was brought before the general clinic, and every senior student has visited and examined him in the ward. He was then able to walk about, the noticeable pathological features being right exophthalmus with paralysis of some of the right cranial nerves.

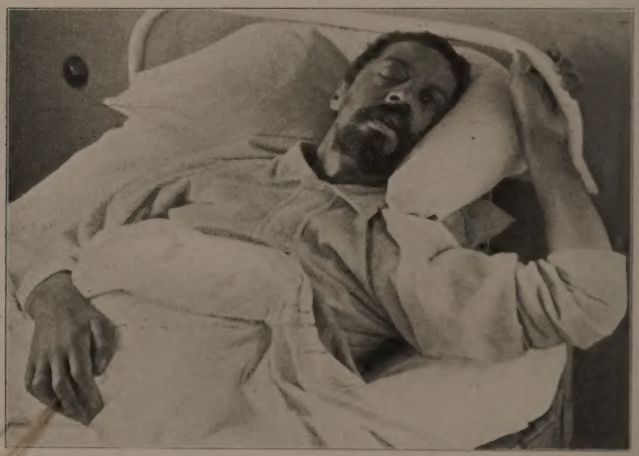


FIG. 2. (Patient in bed.)

View of the patient in his ordinary attitude after hemiplegia set in. Notice the bulging right orb with ptosis, and the characteristic aspect of the right hand. The left eye and arm express vigor.

No particular change occurred in his condition until September 21. He had been wakeful the night previous and began the day in a complaining restless mood, with aggravation of the eye pains. The bowels were loose and moved frequently. He also vomited copiously. At 2 P. M. he had a faint dizzy feeling of five minutes' duration, after which he was weak and exhausted. Then he had in-

voluntary bowel passages and vomited repeatedly, mucus or the milk which was given him, without any sense of nausea or retching. The restlessness passed off and he fell into a heavy sleep, remaining so all night. On the morning of September 22 it was discovered that he had right hemiplegia, and he choked easily in attempting to smallow fluids or solids. At 6 A. M. his temperature was 97 3-5°. Later in the day it rose to 99 2-5°, the well side registering 99° at the same moment.

The left side had been noticeably paretic for three days prior to the onset of the right-sided paralysis, then the left paresis abated. (The muscular tone of the left side remained good to the end.) He told also that during those days of premonition he had had numb sensations beginning in the right hand, extending up to the head and down to the foot, lasting about five minutes at a time.

The usual denial was made of having at any time contracted syphilis, but, anon, there was an acknowledgment of a slight venereal sore some years previous.

A statement made by his wife was more to the point, in that their last child, now two years old, was born a paralytic. She said it had improved some, but was still a helpless thing.

Examination. September 22, 1896. Total muscular paralysis of the right arm and leg, also of the right lower facial muscles. Tongue deviates to the right and the right half is œdematous. Speech thick and utterance slow, but no difficulty in choice of words or comprehension. Mind clear. Anæsthesia of the right supra- and infra-orbital branches of the fifth. Otherwise sensibility of the whole body scarcely affected. The locality and character of sensation from pinching, stroking and pricking readily differentiated on both sides. There is possibly slight delay in transmission of sensation of the right side. He avers that the left fingers and toes feel woolly.

Drooling of saliva since yesterday.

September 29.—During the week which has passed since the oncome of hemiplegia, the patient has complained of intermittent loss of sight of the left eye, for one or two minutes at a time. He describes it as like unto a dark cloud passing over his sight. It has apparently not affected the function of that eye. To-day he can make a slight movement of the right leg. (Eventually this return of the motor function progressed only to the point of a few of the coarser movements of the leg and arm.) The knee reflexes are both exaggerated, the right most. (Subsequently right

ankle clonus and inferior maxillary clonus were occasionally observed.)

The examination of the eyes was made by Dr. C. J. Swan. Herewith is his report:

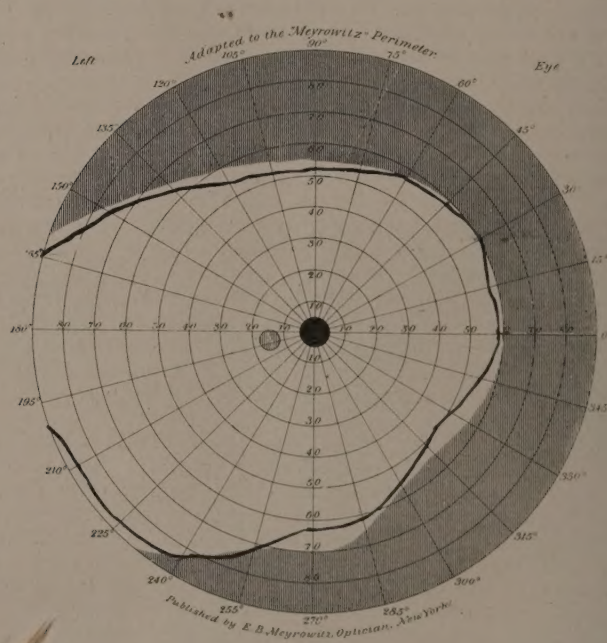


FIG. 3.

Represents the "field of vision" of the patient's left eye as taken by the perimeter. The irregular black line defines the margins of the field, and all the unshaded portion within the outer circle shows what the normal field of an eye should be. It will be seen that the patient's "field" is practically normal. The numbered circles give the angle at which an object may be seen while the eye is fixed upon the central black spot. Vision in the right eye was too much impaired to allow the field to be taken.

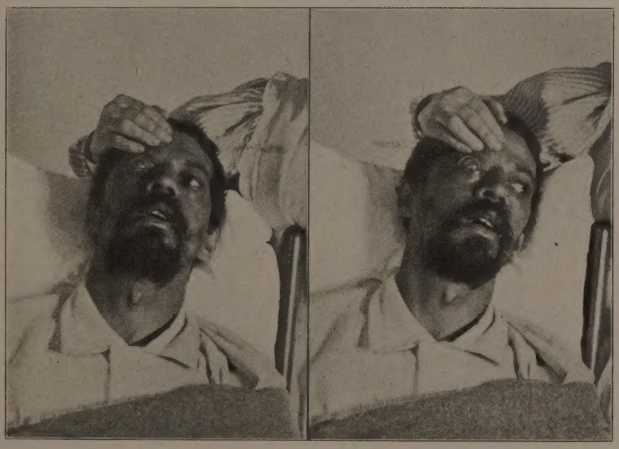
Ocular Examination.—Right Eye: Ptosis; and total paralysis of all external ocular muscles including the four recti and two oblique. Pupil dilated. Paralysis of the circular fibres of the iris governed by the third nerve.

Fundus: Outlines of the disk obliterated; spots of glittering white inflammatory exudate in the region of the disk. Arteries thin and veins distended and engorged. Vision: Counts fingers at six feet.

Left Eye: Muscles and iris not affected, Fundus presents much the same appearancc as the right eye. Vision not so much impaired. Reads $\frac{20}{60}$.

Summary; paralysis of third, fourth and sixth cranial nerves of right side. Bilateral neuro-retinitis.

Subsequent history. This consists chiefly of a long period of waiting for the inevitable end. It differs in nowise from similar bed ridden paralytics. Attendance night and day, dressing the protruding eye, bathing, washing the buccal cavity, which was often most foul, applying lotions to the painful right cranium, administering enemas, chang-



Look to the right. Look to the left.

FIG. 4.

Two views exhibiting the normal mobility of the left eye, and the immobility of the sightless exophthalmic right eye.

ing his position, dressing moderate sized bedsores, keeping up a light diet, and prescribing for pain and insomnia. In our experiments with remedies for the constitutional condition it was early found that the potassium iodide had no such effect upon him as the mercuric biniodide, so that the latter became our chief reliance to render his condition less unsanitary. Not long after Dr. Swan's examination of the eyes, the right one became totally blind, but the ptosis and the motor paralysis for a time were slightly re-

lieved. The patient seldom lost control of the sphincters, and only occasionally became delirious, or somnolent. The temperature ranged from 96⅘° to 99⅘° and the pulse was usually about 100. The general trend of the case was downward, the mental faculties becoming gradually more obtuse toward the last. Dissolution took place on the morning of January 15, without his having experienced a convulsionl during the whole course of his illness.

Diagnosis. The features of the case which lead one to determine the character of the lesion and its location are the recurring headache of a meningeal type, the insomnia, the paralysis of the cranial nerves preceding some time the hemiplegia, and the ocular inflammation occurring in an individual only thirty-seven years of age. Such a combination, even without the admission of a specific history, is sufficient to stamp it intracranial syphilis. The focal symptoms of the right orbit, including the limited anæsthesia, could scarcely arise from other cause than gummatous meningitis. But this lesion would not account for the right hemiplegia, and might not be the origin of the impairment of hearing on the same side. Therefore these various developments must be represented by multiple cerebral lesions. At least, such was the conclusion I arrived at, and expressed before the class when the patient was present for clinical investigation, and the same, formulated in writing, was carried to the necropsy room by Dr. Hunter. It reads as follows: "Gummatous deposit originating in the basal meninges under the right hemisphere, involving by compression or inflammatory exudation the whole of the right motor oculi nerves, possibly involving also the optic and auditory. Also a lesion in the motor tract of the internal capsule of the left hemisphere. Possibly a slight involvement of the corpora quadrigemina, particularly the posterior pair.

General Diagnosis. Syphilitic gumma of the cerebral meninges, with involvement of the arterial coats."

Post-mortem. January 15, 1897, ten hours after death. Performed by Dr. C. F. Stough. Lepto-meningitis, presumably syphilitic Syphilitic gummatous deposit in the pia and arachnoid, the size of an English walnut, under the base and anterior border of the sphenoidal lobe of the right hemisphere, which could compress any and all nerves to the right eye and cause vascular compression. Also degeneration of the right sphenoidal lobe and of the right lenticular nucleus of the corpus striatum, impinging upon the right internal capsule. Small circumscribed area of degeneration in the substance of the pons beneath the left anterior corpus quadrigeminum.

Syphilitic endarteritis and beginning aneurism of the aorta.

Passive congestion of the lungs (slight) and of the liver and kidneys. Perisplenitis, with adhesions to the diaphragm. Probably slight parenchymatous (fatty) degeneration of the myocardium.

The only apparent difference between the diagnostic pathology and the post-mortem pathology is attributing the lesion for the right hemiplegia to the motor tract of the left internal capsule, when the examination proved it to be in the upper part of the pons on the left side. The resulting paralysis from either lesion is identical. It is only when the lower part of the pons is injured that crossed paralysis takes place, the face being involved on the opposite side to the limbs. In the upper pons all the fibres from the opposite side of the body and face have been gathered together preparatory to entering the crus which becomes the internal capsule.

A more careful wording of the diagnosis would have made it read, "above the point of facial decussation," in the same motor tract and hemisphere named. But lesions of the pons are quite infrequent, while those of the internal capsule are most common in hemplegic cases, so that one is justified in looking for what clinical experience teaches to be the usual sequence of events. There is no law governing the progress of syphilitic infection, however, excepting its irregularity.

A case which I reported in 1880* of sarcoma of the cerebrum presents many features dissimilar to the present one but still worthy of comparison. The patient, a lady, was fifty-nine years of age. The only etiological factor of note was traumatism. Twice falling heavily and striking the os frontis. The last injury was one year prior to the development of serious brain symptoms. But for some months there had been insomnia, irritability of temper, loss of memory, fast failing sight and vomiting, without the premonition of nausea. Nothing was apprehended from all this until the patient was taken with a convulsion while out shopping. She lived nearly four months after this, during which time she suffered sixty-four seizures. They were mostly Jacksonian in character, preceded by a distinct aura and followed by clonic convulsions of the left face and left upper extremity. But the most severe attacks were rather apoplectiform, the head being drawn to the left with conjugate deviation of the eyes in the same direction. There was no loss of consciousness in any of these spasms. The vaso-motor system was in a most profound state of irritation, especially during the first few weeks. Ophthalmo-

*THE CLINIQUE, Vol. I., p. 237.

scopic examination disclosed choking of the right disk. The left was clear and distinct. Shortly after the examination of the eyes a neuro retinitis set in which lasted about a fortnight, resulting in considerable impairment of vision of the right eye. The left eye regained its former sight capacity and remained apparently unchanged to the end. The æsthesiometer and the dynamometer shed no light upon the case, for while there was marked vital prostration, there was no paralysis of sensasion or motion until within ten days of the patient's demise.

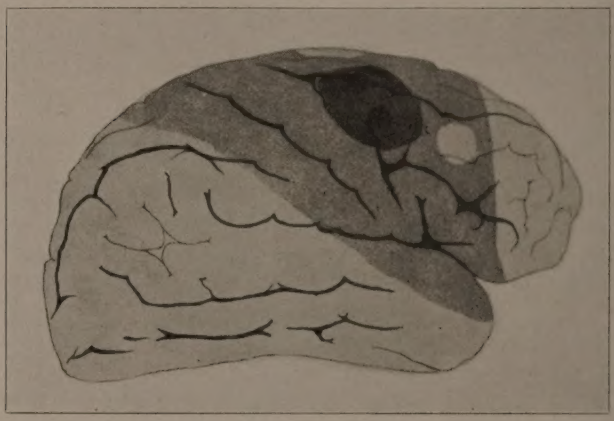


FIG. 5.

Diagram of the right hemisphere. The black portion shows the position of the tumor, with blood cysts. The dark portion shows the widespread area of degeneration. The light spots indicate sclerosis.

The right levator palpabræ superior became paretic two weeks prior to the onset of paralysis of the extremities. The order of progression of the paralyses occurred, first in the left hand and arm, then in the left facial muscles and then in the left lower exremity, occupying four days for their accomplishment. Deglutition and articulation were impaired but there was no aphasia. Coma set in the day after the completion of the hemiplegia and motion of the right leg was lost two days before death. Sensation in the paralyzed limbs was retained, or rather accentuated, like the hyperalgic condition observed in meningitis.

My written diagnosis, handed to Drs. A. E. Small and C. E. Laning, before the autopsy, was as follows: "Cere-

bral tumor of the right hemisphere, commencing over or in the frontal lobe, causing destructive metamorphosis of a portion of the frontal convolutions, extending to and implicating the ascending frontal, the ascending parietal, the posterior parietal convolutions, and the contiguous portion of the superior margin of the left hemisphere."

The report of the autopsy reads thus: On removing a thin segment of the cortex of the right hemisphere a tumor was exposed to view, with some dark blood running from a cyst in its substance. Another similar cyst was broken on manipulating farther, and it was discovered that there were several more in the interstices of the growth. It appeared to be about two and one-half inches in diameter, deeply imbedded in the medullary substance of the bases of the first and second frontal convolutions, and encroaching slightly on the ascending frontal. The surrounding brain tissue had undergone softening, while over a very extensive area the brain substance showed a marked change in color, being of a yellowish hue. This area comprised the bases of the first, second and third frontal convolutions, the ascending frontal, the ascending and posterior parietal convolutions. Two isolated patches in the discolored portions were firmer to the touch than normal. The larger one bordered on the longitudinal fissure near the base of the first frontal convolution.

SUMMARY OF THE TWO CASES OF INTRACRANIAL GROWTHS.

Male, Age 37 Years.		Female, Age 59 Years.
Syphilitic.	Cause.	Traumatic.
Several months. Frontal headache, cough, muscular debility, unilateral deafness.	Prodroma.	Several months. Irritability, loss of memory, failing sight, vomiting, insomnia.
Gradual, unilateral loss of sight, paralysis of cranial nerves, paretic symptoms, insomnia.	Onset.	Sudden, convulsion, no paralysis.
None.	Seizures.	Sixty-four.
Five months after ocular paralysis.	Duration.	Four months after first convulsion.
Right exophthalmus and blindness, bilateral neuro-retinitis persistent in right eye.	Eyes.	Right disk choked, transient neuro-retinitis.
Right oculo motor, right hemiplegia, right orbital anæsthesia, four months before death.	Paralyses.	Left hemiplegia and right leg paralysis, hyperalgia of involved limbs, six days before death.
None.	Aphasia.	None.
Gummatous tumor under right sphenoidal lobe. Degeneration of right sphenoidal lobe and right lenticular nucleus, also area in pons, left side, close to quadrigemina.	Lesions.	Sarcomatous tumor imbedded in bases of right, first and second frontal. Degeneration bases right first, second and third frontal, ascending frontal, ascending parietal.

THE SURGICAL CLINIC.

EXTRACTS FROM PROF. SHEARS' CLINIC IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

CARCINOMA OF THE TONGUE; EXCISION.—I have to present to you to-day a very interesting case of carcinoma of the tongue, brought to me by Dr. Kahle of Harlem, Ill., for the relief of which I propose to make the operation suggested by Mr. Whitehead and known by his name.

Case. The patient is a man forty-eight years of age. For a number of years, he has had some broken teeth on the right side of his jaw. Three months ago the right side of his tongue became a little thick, and in a short time somewhat sore. Pains of a sharp, sticking, darting character became very annoying. The movements of the tongue caused severe pain, and the general annoyance was greatly increased by a profuse and offensive discharge from the surface of the ulcer. Upon the right side of the tongue, you notice, is an ulcer which extends downward to the floor of the mouth, and digital examination reveals an induration extending some distance from the edge of the ulcer almost to the median line on the dorsum of the tongue, and to the right sub-lingual glands anteriorly.

There is only one other disease which presents any such appearance, and that is syphilis. This patient assures me that he has never had any venereal disease, and, indeed, the rapid progress of the disease, the absence of secondary symptoms in the throat or the integument, the lack of involvement of neighboring glands, the pronounced induration, the history of induration before ulceration, the foul secretion and the character of the pain, all point toward epithelioma. I have therefore decided that this growth must be removed. This may be done by the galvano-cautery, with the ecraseur, or with the scissors. I prefer the latter, believing that the consequent sloughing is less, the repair more rapid, and the removal of all diseased tissue more certain by the scissors than by any other method.

How much of the tongue must be removed? Some surgeons recommend the removal of the entire tongue, even

when less than one-half, is involved, urging the plea that the remaining half is useless, being little under the patient's control, besides being liable to invasion by the disease. To the first argument I answer that it is not my observation, for I know that a patient with half a tongue does use it effectively, and considers it of much value; and to the second I reply that the progress of the disease is, as a rule, along the floor of the mouth upon the side affected and into the sub-maxillary gland, rather than across the septum of the tongue. There is, therefore, no more reason for removing this than for removing any other contiguous structure. For these reasons I propose to remove only one-half of the tongue.

The operation is not one of great magnitude, and yet it is beset by many difficulties, chief among which are the giving of the anæsthetic, the difficulty of preventing blood from entering the larynx and producing asphyxia, or subsequent broncho-pneumonia, and the control of hemorrhage so that the different steps of the operation may be so conducted that all of the diseased tissue is removed. A good light is absolutely essential. If you are obliged to operate, as I am, on a cloudy day in the afternoon, the electric light, with a good reflector, proves an adequate substitute for sunlight; indeed I prefer it, as it is entirely under control. I will prop the patient up, and turn him on his side, so that the blood may naturally flow into the cheek pouch, and will rely on my assistants to sponge it out promptly, and thus render a preliminary laryngotomy for fear of asphyxia or hæmorrhage into the larynx or trachea unnecessary. I now open the mouth widely with an O'Dwyer mouth-gag, and transfix the tongue on either side with stout silk threads, each of which is looped and knotted. With the straight blunt pointed scissors I split the tongue along the raphe to a point well behind the disease, and with the string I pull the diseased half forward, and divide with the scissors the mucous membrane between the tongue and the alveolar process, keeping close to the bone. Anteriorly I find this difficult to do, as the

teeth are in the way, so I extract two of the lower incisors, which gives me more working space. Now, having freed the tongue all around, I cut through the muscles between it and the floor of the mouth by horizontal section to a point well behind the disease. It was my intention to proceed to the lingual artery, then cut a groove through the mucous membrane of the tongue, and apply a pair of forceps to the artery before dividing it, but I have been obliged to go back so far and so deep in order to get behind all disease, that I have divided the artery at a point in advance of its entrance into the tongue, therefore I hastily cut off the tongue, and with a pair of forceps grasp the bleeding point in the floor of the mouth. The securing of this artery on the floor of the mouth, or even on the point of the stump, in a pool of blood, is not always an easy matter, but fortunately we have it well in hand. It is well to remember, in premature division of this artery, or when difficulty is experienced in catching it after division, that hæmorrhage is easily arrested by hooking the finger into the pharynx over the stump of the tongue, and drawing this forward, thus arresting the hæmorrhage, and at the same time bringing the bleeding point nearer the mouth. Should the point seem inaccessible from inability to get the jaws wide apart, or should other serious difficulty present, I would not hesitate to slit the cheek back from the angle of the mouth to the masseter muscle, the facial and other small arteries being secured at once. Wounds of the face heal rapidly, and, if careful adjustment is made there is little or no deformity. (See Fig. 6.)

A few other small arteries also need attention, and these being ligated we now have the hæmorrhage under control. For a dressing I will simply brush over the raw surface with a solution of iodoform in ether, and advise the frequent use of listerine as a mouth-wash. I will place the patient in a semi-recumbent posture in bed so that discharges may run easily from the mouth, and will leave the string in the remaining half of the mouth in order that it may at all times be under the control of the attendant.

If the tongue swells we will apply ice, and if he has difficulty in swallowing we will use the œsophageal tube in feeding. The latter, however, I do not anticipate.

The possible complications are: broncho-pneumonia, or abscess of the lung, from septic infection as a result of getting putrid fluids into the larynx; secondary hæmorrhage from slipping of the ligatures; œdema of the glottis from injury, and suffocation from the falling back of the tongue. All these we have guarded against, and success so far as immediate recovery is assured. I must warn you, however, against a too favorable prog-

FIG. 6.

Epithelioma of Tongue, January, 1897.

nosis. In no other locality does epithelioma progress more rapidly toward a fatal termination or more frequently recur than when it involves the tongue. Mr. Butlen says if ulceration has persisted for longer than three months permanent recovery is very doubtful, and if it has persisted for longer than six months, or if the floor of the mouth is involved permanent recovery is well nigh hopeless. Operation, however, is not to be abandoned even in these cases. An operation even though it does not cure will, if properly made, add from six months to one year to the patient's life, and will obviate much of the suffering

attendant upon the extension of the malignant growth. Recurrence in the cervical glands is not accompanied by the agonizing pain, the distressing earache, the foul saliva and the slow process of starvation which is the natural history of carcinoma of the tongue. From the good results obtained from operation in other localities I cannot but believe that when it becomes the practice to advise radical measures in an earlier stage of the disease the mortality of this frightful trouble will be materially reduced. A single ulcer upon the tongue occurring in a middle aged person, which shows no signs of healing under the ordinary methods of treatment, should immediately awaken suspicion. A careful scraping of the surface of the ulcer should be made and the tissue thus obtained should be submitted to a microscopical examination. (This patient made an uninterrupted recovery and left the hospital in two weeks from the time of operation.)

CARCINOMA OF THE UPPER LIP; EXCISION OF THE ENTIRE LIP.—*Case.* Four years ago this man, who is now forty-seven years of age, had his lip cut by the bursting of a gun. One year ago there appeared in the cicatrix what he describes as a fever sore. The edges of the blister were hard, but the sore did not seem to increase any in size until about four months ago. He then consulted a cancer specialist, who applied a plaster, but the only effect was to hasten the progress of the growth. The whole lip is much enlarged and of a reddish purple color. The borders are widely separated, giving a sort of double coxcomb appearance to the part. The growth extends from one angle of the mouth to the other, and from the margin of the lip to the nose, and the discharge is very foul in character.

Let me call your attention to three points of interest in this case: *First*, the location of the growth — cancer of the upper lip is exceedingly rare as compared with similar growths in the lower lip. While I have seen a hundred cases of cancer of the lower lip I can now recall only four cases of such tumors in the upper lip, which have come under my care. Why this decided preference for the lower lip I do not know. *Second*, the general appearance

of the patient—a stronger or more vigorous you rarely see. He has never had venereal disease and every function of the body seems perfect. His father and mother died from old age, and there is no history of any cancerous trouble in any other member of his family. *Third*, the slow progress of the disease for the first seven months and the rapid progress for the last five months. What might have been done for him in the early—I was almost tempted to say the pre-cancerous stage of the disease—had he been submitted to an operation for its radical cure? Then all disease might have been removed with almost absolute certainty by a simple operation. Now a plastic operation of some magnitude will be necessary to cover the denuded surface, and absolute certainty as to the removal of all diseased tissue is quite impossible.

Operation. I will remove the growth by making two perpendicular incisions through all the tissues of the lip, from each angle of the mouth upward to the level of the alae nasae, and then connect them by a transverse incision touching both alae and the nasal septum. This leaves a large quadrangular space to be covered by a plastic operation of some kind. There are several methods of operating for the restoration of the upper lip. Of these the ones known as Diffenbach's operation, the Sedillot operation and the Szymanowski operation, seem to me the most practicable. I shall adopt the last named method and obtain flaps by extending incisions the full breadth of the lip, on each side of the face, including all the tissues of the check. The incisions start from the upper angle of the wound, near the nose and from the angle of the mouth and curve downward until the ramus of the jaw is reached. The flaps thus made are drawn upward and sutured in the median line.

By pulling the mucous membrane outward and suturing it to the integument a very presentable vermilion border is given to the lip, and on the whole the appearance of the patient is, as you see, not disreputable. The wound healed promptly, and ten days later when the patient was

presented to the clinical society, all incisions were united, and from the appearance of the patient it seemed incredible that so extensive an operation had been made.

ACUTE OSTEO-MYELITIS WITH NECROSIS OF THE HUMERUS; REMOVAL OF A SEQUESTRUM COMPRISING THE ENTIRE SHAFT. —*Case.* Six months ago this little boy, now thirteen years of age, first complained of pain in the left shoulder. The affected parts began to swell and the boy was placed under treatment for inflammatory rheumatism. In three weeks an abscess developed which was lanced. By this time the whole arm was much swollen and very painful. Prof. Evans, under whose charge he now came, recognized the true condition and sent him to the Hahnemann Hospital. Examination at that time showed complete separation of the periosteum from the shaft of the humerus from one epiphyseal junction to the other, with a commencing deposit of bony material around the old shaft of the bone. This was not sufficient to maintain the stability of the arm, and as I believed with free drainage no danger to the child's health would result, I determined to leave the old shaft of sequestrum, within the involucrum to act as a sort of splint until the latter had become sufficiently firm to maintain the form and strength of the arm. The boy has remained in the hospital for two months under observation, and as I believe the time has now arrived when the new bone is strong enough to maintain the form of the arm, I propose to remove the diseased shaft. I will make an incision along the outer side of the arm, from just below the tip of the acromion to the external condyle. The involucrum, or new cylinder, is composed of soft bone perforated at three points where drainage has been maintained. With the chisel I split this from one end to the other and lift out the sequestrum, which as you see, comprises the whole shaft of the bone from one epiphyseal junction to the other. (See Fig. 7.) After complete removal of all granulations, cleansing with peroxide and wiping with iodoform gauze, I will close the wound and allow the cavity to fill with a blood clot after the manner of Schede. As this wound is, I believe sterile, I hope for the rapid organization of this clot and closure of the wound in this way, without a long process of suppuration and cleansing.

There are several points of interest to which I desire to

call your attention: *First* the early diagnosis of rheumatism. This is a very common mistake. Hardly a case of osteo-myelitis comes to me in which this diagnosis has not been made, and it is all the more important because a true diagnosis having been made, early surgical measures may prevent such disastrous results. It should be remembered that rheumatism of an inflammatory character rarely

FIG. 7.

Sequestrum of Humerus.

affects a single part. Its lesions are multiple. Rheumatism is not so painful as osteo-myelitis nor is there the same evidence of a constitutional disturbance as is shown by inflammation of bone. Moreover, rheumatism is not followed by suppuration.

Second, the limitation of the disease to the shaft of the

bone. In children the epiphyseal cartilages often form a barrier to the advancement of disease and thus the joint is saved. As in this case, the periosteum is perforated at each end and there is acute necrosis of the shaft but the articular ends remain intact. If then a stable involucrum is formed the patient may escape without loss of motion and with but little change in the length or contour of the limb. In adults, where the epiphysis and diaphysis are united this takes place less often and indeed the joint ends are often primarily involved and perforation of the joint cavity is a common occurrence.

Third, the treatment. As foreshadowed by my remark on the diagnosis, the disease is at all times a surgical one. No time should be lost in making an incision down to the periosteum, laying this open and then, with a bone drill, perforating the bone. If purulent or serous fluid exudes the diagnosis is verified and the diseased bone cavity should be thoroughly opened by cutting a groove or channel from one end of the diseased area to the other, even if the whole length of the shaft is involved. The entire cavity must then be scraped clean and disinfected. By this means the necrosis may be limited and much suffering and deformity prevented. The relief from pain and the disappearance of septic symptoms after the operation, are followed by a marked improvement in the general condition of the patient. I expect in this case a prompt regeneration of tissue and a useful limb. (The patient improved rapidly after the operation, the wound healing by first intention and without suppuration.)

Clinical Society Transactions.

CORNELIA S. STETTLER, M. D., Corresponding Secretary.
ORRIN L. SMITH, M. D., Recording Secretary.

JANUARY MEETING, 1897.

The monthly meeting which closed the twentieth year in the history of this Society was held in the amphitheatre of the Hahnemann Medical College on Saturday, January 30, at 8:30 P. M. About a hundred earnest physicians and students were present to hear the

REPORT OF THE SECTION ON CLINICAL MEDICINE.

W. E. TAYLOR M. D., Chairman.

VII. Syphilis and mercurial poisoning. By Dr. W. E. Taylor.—*Case 1.* G. S., age 33; weight about 200 pounds; saloon keeper by occupation. Called me three years ago to treat him for paralysis. Two years previous he contracted syphilis. The initial lesion was very insignificant, healing in a few days after having been cauterized and treated with iodoform. His physician gave him large doses of mercury (blue mass and the iodides) which was continued, with a few intermissions, for two years. Soon after the appearance of the initial lesion the lymphatic glands nearest to it became enlarged and indurated, but at no time did they suppurate. Skin lesions characteristic of secondary syphilis, did not manifest themselves, nor did the mercury produce ptyalism. About one year after contracting the disease he experienced a heaviness in the bowels, a dragging sensation in the stomach, a tenderness in the region of the liver and spleen. His bowels were constipated, and the urine which deposited a thick, whitish sediment, emitted a very strong ammoniacal odor. Eight or nine months before I was called he began to experience dull nocturnal pains in the head, the mind became dull, the speech slow, memory faulty; and a little later he had severe pains in the long bones which at night were almost unbearable. His tongue grew thick and heavy, his mouth and throat became numb, causing deglutition and speech to be

quite difficult; his gait was unsteady; and as the disease progressed he grew weaker and could hardly walk; his limbs trembled as in a drunkard; and he experienced severe pains in the muscles on motion, and the muscles would become rigid at times. One peculiar characteristic of the remedy which I prescribed was this, if I suddenly tapped the tendon or muscles of the leg with something hard it would cause convulsive paroxysms, and the leg would be suddenly drawn up, and the muscles of the calf of the leg would become knotted. Finally he became helpless; his right side being completely paralyzed, except the eyelid, and he had very little use of his left side.

During the two years under mercurial treatment he had continued to drink more or less whisky but could not be regarded a drunkard. At the time I was called his speech was almost inaudible; his mind worked so very slow that I was obliged to spend several hours in getting his history. He was unable to help himself even in the slightest way, and he laid in bed like a lump of lead; his bowels moved only by aid of powerful cathartics and enemas; the peristaltic action of the intestines seemed to be entirely lost and his urine would flow very slow, and then only when the bladder became quite full, which was but once a day. The liver seemed to be atrophied, hard and slightly tender; the muscles were flabby, and at times twitched and jerked involuntarily. If his knees were flexed perpendicularly violent tremors would take place. Frontal bone pains and pains in the long bones of the leg were simply frightful at night, cutaneous sensation was impaired slightly; he had no fever during the day but at night the temperature was about 100; his skin was dry and withered, and the cutaneous exhalations had a sour or musty odor.

I prescribed nux vomica 6x, in two grain doses, four each day. The physic was discontinued. I had him drink as much filtered rain water each day as he could swallow, and I had his spinal column rubbed rather harshly from the occiput to the coccyx at least one hour each day. The fourth day the bowels moved very freely, and continued to move at intervals of three or four hours for four days, and have been moving regularly once or twice a day since. The pains lessened each day; gradually he gained use of his limbs and body, and in three months was able to visit my office, and since has been doing a man's work at manual labor. If he exhausts himself or becomes heated or receives a sudden start he will experience a slight numb-

ness in the right arm and leg for an instant, and occasionally feels spasmodic jerkings, but otherwise he seems perfectly well. During his course of treatment skin lesions, only of a macular variety, however, occurred on his forehead and face but would disappear in a few days.

Case 2. Mrs. C., age thirty-five, apparently strong, plethoric, but not healthy appearing, having a scrofulous constitution, had suffered with menorrhagia for about one year. The flow was very profuse; came on every twenty days, and would continue about one week; the blood was bright red, not inclined to coagulate. Three years previous she contracted syphilis, the initial lesion appearing on the lip. She was placed on mercurial treatment by an old school physician, and in course of two weeks the ulcers healed, but six weeks later the glands of the neck became indurated; mucous patches formed in the mouth and throat; the tonsils became ulcerated as well as the gums, which were soft and spongy and oozed blood when touched. Six months after she suffered excruciating pains through the malar bones and internal ears at night; during the day she was more comfortable. The glands of the neck remained swollen for several months, and she experienced sharp, shooting pains through them and into the throat, but at no time did they suppurate; eruptions appeared upon the chest in the region of the liver and on the thighs, which would burn and sting after getting warm in bed; and scratching would always cause a bleeding. She had also been afflicted with warty excrescences. At times she would spit a bloody mucus, and in the morning blow bloody mucus from the nose, which was sore and at times would become excoriated. Her symptoms were alleviated during the menstrual flow but between the periods she suffered violent bone pains at night, and nodules formed along the line of the tibia, back of the ears, and on the temporal bone; her liver was greatly enlarged, and her appearance indicated that she was suffering from jaundice. The slightest scratch would bleed profusely, and her blood seemed to be very thin. I gave nitric acid, six drops of the chemically pure in a glass of water, one teaspoonful every three hours, which relieved her of all her sufferings. I continued the treatment after she was relieved of her pains, giving two doses a day for a period of several months before the menstrual difficulty was regulated. She is now perfectly well so far as I am able to discover.

I selected nitric acid, as it is especially adapted to dis-

eases depending upon some virulent taint, especially in scrofulous subjects; the greatly enlarged liver; profuse menstruation; burning in the ulcers with the burning itching of the skin lesions and the warty excrescences.

Case 3. Mrs. D., age twenty-eight; light hair; blue eyes; scrofulous constitution; contracted syphilis six years ago. The initial lesion was very slow in healing, and two months after contracting the disease a macular eruption appeared on the forehead; and later the characteristic syphilitic eruptions appeared on various parts of the body which continued with slight remissions until three years ago, when nodular or solid tumors began to form in the connective tissue between the foot and knee. These tumors, or gummata, varied in size from a pea to a hazelnut. They grew gradually until fully developed, and then in the usual way underwent ulceration. When I was first called the ulcers appeared very formidable, being deep and undermining; their floor was uneven, covered with broken down tissue, and they discharged a sero-purulent secretion. The edges were inclined to slough and contiguous ulcers would join; the glands of the neck, axillæ and groin were enlarged; the liver and spleen were tumid; and while the kidneys acted very often both day and night, the urine was scant, high colored and of a strong odor. She suffered nocturnal pains in the head which were maddening, and during the attack small tumors would form in the frontal and temporal regions which would relieve. She also suffered severe pains, especially at night, in the joints and long bones, and there were indications of gummata in the periosteum of the tibia, which was enlarged, owing probably to a deposit of neoplasm in the periosteum. She also suffered from catarrh, leucorrhœa and discharge of water from the eyes, which were probably the result of the long continued use of the iodide of potash. This patient had never taken mercury, but from the time of the appearance of the initial lesion to the time I was called she had been under the continual influence of iodide of potash. For the ulcers I used mercuric oxide cerate, and gave internally iodide of mercury 3x and a few doses of sulphur, which cured the case.

Case 4. A woman about 43 years of age, weight about 200 pounds, contracted syphilis four years previous, had taken medicine constantly. First she was salivated with mercury; after that mercury was rubbed on her body until as she said, she "took the rheumatism;" then she dosed her-

self with patent medicine, iodide of potash, and now and then returned to mercury. When I was called her mental condition was most deplorable; she had a great loathing of life, exhibited hopelessness and utter weariness, talked about suicide and said she wanted to die; she was gloomy all the time, complained of rush of blood to the head; head felt full; felt at times as if the bones were being crushed, especially at night; when lying down, her eyes throbbed and ached; felt as if they were being pushed out of their sockets; and the pains were aggravated by light and noise, and at times she saw sparks before them. The pains in the bones, especially the long bones, were excruciating; felt as if they were being crushed; was obliged to get out of bed and walk about the room to obtain any relief. She had varicose ulcers on the right leg just above the ankle which were very obstinate. Her liver was atrophied, the skin was very sallow, indicating a jaundiced condition. The urine was of a very strong odor, deposited a sediment, and was scant. From the time she contracted the disease until I was called she suffered from various skin lesions characteristic of syphilis; her hair came out, and she experienced the fever characteristic of mercurial or syphilitic poisons. I gave aurum mur. in the thirtieth potency, three doses each day, and she made a very speedy recovery, taking no other medicine nor receiving any other treatment.

The most important feature of her case was the depressed condition of her mind, which is the most important effect that aurum produces. Also the ulcers and other skin lesions were characterized by burning, itching and great tenderness, worse in the cold air, better in the warm room and from moving about.

Remarks. The cases just recited are in no respect extraordinary, as all physicians are called upon to treat similar ones in their daily practice; nor do I desire to depreciate mercury in syphilitic diseases if properly given; but I do want to impress upon your minds the fact that the reckless use of it in syphilitic diseases is responsible for more suffering than is the disease for which it is given. The syphilitic poison enters the system through the medium of the lymphatics, and its first shock is upon the sensorium that presides over the function of that system. Mercury does the same thing, and when given in homœo-

pathic doses meets the venom of syphilis upon its selected ground (the lymphatics) and there, by some dynamic force, destroys it and becomes a blessing to humanity; but if given in large doses it shocks the lymphatic capillaries, diminishes and paralyzes their irritability, contractility and life-making power; and because of that they become engorged, and finally innumerable phenomena result which wreck the machinery of man. I will not discuss the pathology of these cases, but justify my prescriptions, which in part are not syphilitic remedies. While the symptoms indicate a condition analogous to that produced by syphilitic virus, I believe the phenomena produced by a combination of the two poisons must be met with other remedies, according to symptoms. For instance: In the case of paralysis there was a loss of the peristaltic action of the bowels, causing torpor; trembling of the limbs; staggering as in a drunkard; electric-like shocks, or jerking of the tendons when in contact with external objects; rigidity and convulsive contraction of the muscles; weariness, exhaustion, loss of strength, and many other symptoms which indicate a morbid condition both in the brain and spinal column, upon which nux vomica primarily acts. The constipation and torpor of the bowels undoubtedly resulted from a deficient secretion of bile. The slow flow and retention of urine owing to a torpid condition of the muscular fibres was undoubtedly due to an irritation in the lower portion of the spinal cord.

In the case of ulcers I did not regard kali as a syphilitic remedy, but believed I had a picture of the iodide of mercury with a few symptoms, especially mucous membrane conditions, which were probably due to the long continued use of the potash. The scrofulous constitution, the maddening head pains, the development of soft tumors on the temporal and frontal bones, the formation of gummata and resulting ulcers, and the enlarged glands guided me in selecting the remedy.

In the case of menorraghia I prescribed nitric acid, not because it is a syphilitic remedy, but because mercury

increases the leucocytes and decreases the blood globules, or in other words thins the blood and thus predisposes to hæmorrhage.

VIII. CLINICAL NOTES ON A CASE OF TERTIARY SYPHILIS. BY DR. C. D. COLLINS.—*Case.* Mr. S., æt. thirty-five, unmarried, of German extraction, lymphatic temperament, light complexion, and in full habits of life. When twenty years of age he contracted syphilis, as was evidenced by a typical chancre, which lasted about six weeks; also inguinal adenitis, and slight but typical maculation. He was treated for the same by his family physician, who, after two or three months' treatment, erroneously pronounced him *well*, because all local manifestations of the disease had disappeared. All treatment was discontinued, and he enjoyed the best of health for a period of fourteen years, when he began to suffer from impaired vision, otherwise he was perfectly well. He consulted an oculist, who examined his eyes, and pronounced them normal, except a marked dilatation of the left pupil as fully as if under atropine, and consequent impairment of vision. All other symptoms were negative. No headache, no strabismus, no diplopia, no pain, nor was there any impairment of the right eye.

About his shoulders and back were a few scattered papules and atrophy spots, which gave him no inconvenience, and which he did not even know existed. This same oculist prescribed glasses for him, but to no effect. He finally drifted into the policlinic, was again examined by an oculist, who did nothing for him but to turn him over to the venereal department. Here he was given potassa iodide, probably. He took a couple of doses, and became deathly sick with gastric cramps and vomiting, intense pain in the head, neck and throat, with a marked swelling of the lymphatic glands, especially of the deep cervical and the sub-maxillary glands, so that mastication, deglutition and talking were very painful, in fact almost impossible. With this he had a hot watery diarrhœa, as though so much liquid fire was passing.

This train of symptoms persisted for a few days only, during the height of which his eye symptoms entirely cleared up. But as he gradually returned to his normal health, his eye gradually resumed its dilated state again with the usual impaired vision, amounting almost to a total blindness. There was but feeble response to light in the affected eye, but the opposite eye was normal.

Such was his condition when I first saw him, leading me to the diagnosis of tertiary syphilis with gumma impinging on the motor oculi, with partial paralysis of its ciliary division. After reviewing the case I concluded that kali jod. was the remedy and began giving it cautiously in three grain doses three times a day, but only to find that it excited a repetition of his former experience. I then put him on the thirtieth potency, hoping to win, but he received no benefit after a two weeks' trial. At this juncture a boil appeared on his back which broke and discharged quantities of a thick yellowish-green pus. During the entire time that it was discharging the left pupil assumed the normal size, or nearly so, and he could see perfectly, but it again dilated upon cessation of the discharge. This led me to the following query: Why not establish free elimination and free evacuation during the time of medication? I accordingly ordered him to take a Turkish bath twice a week; drink an abundance of water, and gave him a cathartic pill of aloin and croton oil $\frac{1}{10}$ gr. each every second night. I then returned to the kali jod. in three grain doses; this time, however, with only slight constitutional disturbance, but with marked improvement of the eye. In two or three weeks I increased to ten gr. doses four times a day, which was tolerated well so long as elimination was kept up, and the ocular results were entirely satisfactory.

This line of treatment was pursued for about three months with the satisfaction of seeing the pupil and vision return to about the normal. He was then given the proto-iodide of mercury 3, four times a day, for the following two months which is up to the present date. He is now feeling well and can read an ordinary newspaper, but at times the left pupil is seen to be slightly larger than the right.

This case suggests the following points: 1. That *elimination* in the treatment of tertiary syphilis is as essential as medication, especially in the *lymphatic* temperament. 2. Those who have marked secondary lesions in the way of maculo-papular eruption, and mucous patches, will have only a mild tertiary stage and *vice versa*. 3. The remarkable vital resistance of his organism to successfully fight down this virus for fourteen years. 4. The tolerance of lymphatic temperaments to syphilitic poison and their re-

sistance to treatment. 5. That gumma syphilitica may affect not only an individual nerve but any one branch of that nerve. 6. That kali jod. has an arousing action on latent syphilis and is particularly operative on the lymphatic system.

DISCUSSION: Dr. H. V. HALBERT: I have been very much pleased with Dr. Taylor's paper, because he has shown us the value, and, at the same time, the dangers of mercury in the treatment of syphilis. I believe the value is found in its homœopathic use. I still consider it a useful remedy when it is used with caution and consideration. Without doubt much of the eruptive symptomatology in syphilis comes from the excessive use of mercury, and it is very important to know whether we are treating mercurial conditions or true syphilitic eruptions. In the beginning of the disease, I frequently use mercurius biniodide 3x for some time. As the disease improves I use a higher potency and do not give so frequent a dose.

I am still partial to the use of potassium iodide, especially in the initial stage. I must confess that my experience has favored the saturate solution; however, as the condition improves, I use a more dilute form. Some have objected to a poteney with this remedy. I am just as positive that it affords good results in that form. It should be given, though, for a long time, in order to avoid the dangerous nervous lesions in later years. When there are pronounced signs of nervous disturbance, in the secondary or tertiary stages, I have always found nitric acid or argentum nit., in potency, were more serviceable. I am sure that these remedies will do more for us than the continued heroic dosage.

Another point I would like to make is the necessity for persistent treatment. Too many physicians consider the disease cured when the eruptive symptoms disappear. Herein is the greatest danger, for the after results are likely to appear in the form of locomotor ataxia, or some cranial nerve palsy. Optic atrophy is often a sequel of syphilis, but if the initial disease is treated long enough

this will not occur. I generally demand that a patient shall be under my care for several years. It is not necessary always to keep them under medication, but we should be constantly on the watch for some unfavorable symptoms.

I am surprised, every day of my life, at the number of chronic diseases which can be traced to syphilis directly or indirectly. It has a peculiar affinity for the nervous system. I fear that we are not always careful enough to ascertain this, or persistent enough with our treatment.

Another thing I like about Dr. Taylor's paper is the reference to other remedies than the mercurials. I believe the homœopathic principle should be applied in these cases as well as in others. He has surely demonstrated this by the report of cases.

Dr. ALFRED C. CROFTAN: A few words only about the probable action of nux in Dr. Taylor's first case.

The consensus of opinion among modern pathological anatomists sees the primary and essential lesion of all syphilitic affections, "primary, secondary and tertiary," in a fibroid change of the media of the arteries and capillaries, followed by a rigidity of the vessel walls and a narrowing or obliteration of the lumen. Deficient blood supply to the areas supplied by the affected vessels is the result, and many of the innumerable syphilitic affections can be explained by malnutrition and subsequent functional inactivity of the different parts supplied by the diseased blood vessels. Thus, gummata are simply small areas of degenerating tissue which ultimately undergo fibroid changes, etc. In the nervous system those sclerotic changes occur most frequently and produce the varied pictures that are grouped under the names of multiple sclerosis, amyotrophic lateral sclerosis, tabes, etc., syphilis, we know, being the chief and possibly the only etiological factor in the production of these different scleroses. In Dr. Taylor's case we have the symptoms of spinal inanition, *i. e.*, pareses, visceral crises and paræsthesias, probably the result of the first stage of degeneration of different

fibre tracts and columns. Now we know that strychnine is the best spinal irritant and excitant we have, and it seems very probable that the nux administered, by irritating and stimulating the undertoned spinal areas that were being affected by the syphilitic change, together with the mechanical spinal irritation that the doctor employed, brought those areas back to their normal functional tone and thus produced a cure; and it seems to me that where a physiological explanation of the drug mechanism, based as it is on the knowledge of positive pathological conditions, is possible, it is hardly necessary—in fact not admissible—to coerce the hypothesis of a dynamic or other unexplained force into service, where a simpler explanation is so apparent.

Dr. C. Gurnee Fellows: I am glad to know that there are some who look at the prognosis of this disease from a favorable standpoint, for I am skeptical as to the results of treatment, from the fact that I see a great many incurable cases in my practice. To be sure these are the results of past trouble, which may have been curable according to discussion, but at present are not cured. I refer to pathological changes found by the ophthalmoscope in the fundus of the eye. Choroiditis, retinitis, etc., are invariably followed by atrophy, many times occurring years after the initial lesion. Sight may still exist in the unaffected parts of the retina, but useful vision is for the most part gone. I must differ with Dr. Halbert in two points: as to the length of treatment and as to the proportion of cases complicated by this affection. I think a great many cases, possibly, are affected, but not 95 per cent, and we cannot begin our treatment with the grandfather, but must continue it to the grandchildren. According to the foreign clinicians two years is the regulation time for treatment, although we would actually treat them for the rest of their lives. If we have accomplished nothing in two years we might not in five.

Dr. F. H. Honberger: The paper presented by Dr. Taylor is a very excellent one and the cases cited are fair

specimens of those that the general practitioner must frequently combat. I think somewhat in the line with Dr. Halbert that these cases must be kept track of for some time. My practice has been to notify such patients upon their first visit, that unless they will closely follow out instructions, and continue their treatment at intervals for about two years after all local manifestations of the disease have disappeared, they could not be considered cured; and that they might expect symptoms of the disease to reappear in some form perhaps after the lapse of a few months or even years. Unless you can keep track of your patient for a long time you had better tell them to consult some other physician, or they will say that they were treated by you but that you had failed to cure the disease. During the past five years I have had at least five or six patients come to me in the secondary stage, with the history of having been treated for a few weeks, by a physician who had used cauterization of some kind to heal up the primary ulcer. As soon as this healed they were discharged and given every assurance that they were entirely cured and would never have further trouble, but in each case the secondary eruption appeared in from two to four months from the time of the supposed cure.

Dr. R. Ludlam: The general idea of Dr. Taylor's paper strikes me as very sensible and suggestive; for there certainly is a great deal of confusion in medical practice from the admixture of drug effects with disease effects. The best physician in the world could not possibly tell "vich is vich" when the quinine cachexia is compounded with the symptoms of chronic malarial poisoning: nor could he do any better in a case of insanity that is being treated by old-school remedies, where the mental symptoms induced by drugs are so often confounded with those of the disease. Mercurial overdosing in syphilis, and in certain forms of rheumatism obscures the case, befogs the doctor and plays the mischief generally.

The more nearly the pathogenetic symptoms of the

drug correspond with those of the disease for which it has been given in heroic doses the more difficult it will be to discriminate between them when they coëxist in the same patient. This goes without saying, and yet there are many physicians who never fail to forget that drugs, as well as bacilli, are not always innocuous, but are often pestilent to a high degree. It must be true that the growing disbelief in the efficacy of medical treatment is largely due to the confusion that arises from this cause.

Whether the identity of syphilis may be so altered by therapeutic blundering and coarse medication with the mercurials as that it shall fail to respond to treatment that otherwise would have been specific and successful, is a very interesting question. And if the hybrid affection must be treated as a condition, with little or no regard to its peculiar, mixed and misleading symptoms, the rule of practice will need to be modified not only in old cases of syphilis that have been driven into such a rut, but in many other diseases as well. This is the only theory upon which Dr. Taylor's success in the four cases cited can be explained. It furnishes an excellent clinical lesson, and warns us not to treat all our cases as if they had come to us, medically speaking, in their virgin purity.

The twofold reputation of nitric acid as an antidote for mercurial poisoning and as anti-hæmorrhagic, in memorrhagia especially, furnishes a double explanation of the cure in the second case on the doctor's list.

Dr. C. D. Collins: Syphilis is a disease that affects every tissue in the body. The lymphatic system, the nervous system, the blood and bone, and hence, since it has such a wide sweep of pathology, it is only reasonable to believe that many remedies will be indicated from time to time and no remedy is exempt from an occasional call in syphilis. As for nitric acid, I have never had any satisfactory results from it except in the higher potencies. It is my practice in syphilis to begin moderately low and then go higher as the case improves; also the more chronic the case the higher the potency of the remedy.

I believe we often become so engrossed in the use of

our remedies that we entirely overlook such auxiliary measures as bathing, food, hygiene, etc., which, if carefully applied, would very materially assist us in accomplishing a cure.

Dr. TAYLOR, in closing the discussion, said: I do not desire to be understood as depreciating the value of symptomatology, for oftentimes a very insignificant symptom will be the keynote in directing us to the proper remedy; but I contend that oftentimes conditions must be paramount to symptoms, and that certainly causations must in some cases be met by the dynamic force of a remedy which has a peculiar adaptability to the primary poison of the disease, and that in those cases constitutional symptoms must not govern us. Syphilitic poison may produce an innumerable number of symptoms, many of which are characteristic of drugs which are in no way adapted to syphilis, hence I say conditions and not symptoms must be regarded in the treatment of this very formidable disease. Mercury permeates every tissue of the body; it gains access through the same organs, viz.: the lymphatics, that does syphilitic virus, by a process of congestion or engorgement it produces objective lesions and pathological conditions almost, if not quite, identical with those of syphilis, and experience teaches us that it hushes up the venom of the disease. One form of mercury may act best on one subject and another of different constitution may require a different combination of the drug, but I believe we will find no other remedy in the materia medica which meets this specific poison as does mercury. When mercury fails to produce the expected result it is because of some peculiar condition of the absorbents, and then we are called upon to give iodide of potash for a short time, or possibly some other inter-current remedy, but must return to our mercury if we expect to eradicate the disease permanently. I do not regard aurum, nitric acid, nux vomica or any of those remedies as as anti-syphilitic, but believe that conditions produced by large and frequent doses of mercury given for the cure of syphilis must be met by remedies such as I have mentioned, drugs which I do not regard as anti-syphilitic.

IX. The relation of psoriasis and myxœdema. By Dr. H. V. Halbert.—The obscure features of a disease are often better understood by pathological comparisons. To a certain extent treatment may thus be facilitated; at all events we may, in this way, come nearer to a scientific knowledge in diagnosis. In a variety of diseases we often find that many of them portray symptoms of a common origin; this is so frequently evident that possibly a closer study might prove such an alliance of morbid developments that would subtract much from our medical nomenclature.

The first observation does not show a positive relation between psoriasis and myxœdema; and yet there is so much of similarity in the habit of the two afflictions and so close a relevancy in their symptomatology and treatment that, to me, the consideration of this subject has been of great interest. Both are obstinate diseases and if the following comparisons will open up a field for future study I shall feel that something has been gained by this paper.

Psoriasis is a neuro-vascular change attended with more or less hyperplasia of the rete cells. It results in a secondary isolated inflammation which gives the characteristic eruption. This is well enough understood to permit the exclusion of a detailed description. There is much contention regarding its minute pathology and opinions are divided between the microbe theory and a purely nervous lesion. While this dispute is still unsettled there seems to be sufficient ground to consider it, symptomologically at least, from a nervous standpoint.

It is not associated with any general debility nor does it date from any particular toxic invasion so far as we can find. It affects those who are apparently robust and healthy and it has no exemption for the young or old. It would seem, however, that those of nervous temperament suffer most severely; it is moreover incident to fright, worry, exhaustion and general neurasthenic depletion. No definite motor or sensory lesion can be discovered and therefore we are left to infer that the involvement pertains to the sympathetic system. Hence the term "neuro-vascular disease" is applicable.

Myxœdema is a slow developing disease which also is not thoroughly understood. It is associated with atrophy of the thyroid gland; a physical examination reveals a solid œdema due, no doubt, to an increase of cellular ground substance which yields an excess of mucin. It gives the appearance of a local tumefaction of the skin

and a general increase of weight which upon test is not always true. It is also characterized by pronounced mental inertness and sluggishness of the skin function; thus an increase of scales generally attends the disease throughout; this is often so extreme that it produces epidermal shedding resembling a fine white powder.

The small veins and lymphatics of the skin are generally dilated and the connective tissue of the corium is decidedly increased. In the sweat and sebaceous glands the epithelium of the tubules is excessively swollen. There is also an imperfect nutrition of the hair follicles with the attendant scaly excretion resembling dandruff; this generally produces baldness.

If we examine the mouth and fauces it will be found that the mucous membrane is turgescent and infiltrated. The temperature, if regularly taken, is generally subnormal—a fact not always noticed. It may also be said that a low temperature aggravates every symptom. A careful observation will discover some derangement of coördination, abnormal sensations and something of muscular tremors.

The temperament is irritable and suspicious, bordering upon dementia. This is often so pronounced that the patient not only doubts the world in general but loses absolute confidence in himself. I have seen this so marked that it was difficult to administer remedies or demand the requirements of cleanliness. All of these symptoms grouped into one expression, describe a vaso-motor deficiency which results in a metabolic depreciation and a nervous debility.

If now we compare the symptoms of psoriasis we shall find, like myxœdema, that it is a slow developing disease; the eruptive signs may appear suddenly, but if we get a perfect history, it will show previous signs of scrofula or at least an unhealthy skin; whether it has any connection with thyroid atrophy I am not prepared to state; I have a strong suspicion that, some time, we shall find this to be true. In many of my cases I have been satisfied that there was either a congenital atrophy or a slow developing one before the psoriasis appeared. We do not find the same œdema as in myxœdema, yet it will always be noticed that the psoriasis patient is rotund and well padded with cellular tissue; frequently the lips are swollen and the face and eyes give the full moon expression. I have observed also that these patients have a similar mental in-

ertness and sluggishness of habit; this is often seen in the slowness of speech much like that of multiple sclerosis; it is due probably to a cortex vaso-motor perversion which permits neuroglia increase or induration which dulls the mental activity and inhibits motor action.

The most pronounced resemblance is noticed in the dry skin and the tendency to form scales is pathognomonic of both diseases. In psoriasis it is more localized and excessive, due to the circumscribed inflammatory invasion of the integument. I have not been able to discover so much involvement of the mucous membrane of the throat and fauces, and yet a post-nasal atrophic catarrh is frequently a symptom of psoriasis. The veinous dilatation and connective tissue increase in the corium is quite constant in both diseases.

A low temperature, to my mind, is also conducive to aggravation in psoriasis as well as in myxœdema; and as regards the abnormal sensations and derangement of coördination I think we may claim it as a distinct feature of psoriasis, though the sensory invasion will be a little more pronounced.

If these comparisons are symptomatically and pathologically true there ought to be a proportionate relevancy in the treatment. From a homœopathic standpoint arsenicum has been looked upon almost as a specific, and I am inclined to the belief that it is still a valuable remedy in both of these afflictions. Unfortunately it is not always serviceable and the similimum is not easily found.

Since Bromwell's experiments with thyroid extract in myxœdema the profession has given considerable attention to this remedy. The results in myxœdema have been more favorable than in psoriasis. Many still claim that it is injurious, particularly in its after results. The truth is it is not indicated, any more than other remedies, in all cases. The danger lies in the overuse, and the principle of "thyroid feeding" should be discouraged.

Thyroidine, as a potency, is surely a valuable adjuvant in both diseases; its heroic use is less harmful in myxœdema, but I believe we shall find its greatest therapeutic value (in potency) in psoriasis. There are conditions which should preclude its use. It should *not* be given to old people or any patient with a weak heart; it should *not* be used in the developing stage of psoriasis nor in extremely hyperæmic cases. It has been most successfully employed, in both these diseases, when the case was one of

rapid development. When the conditions are favorable I would earnestly recommend it in psoriasis. It must however be given with caution and must be continued for a long time. When an aggravation of the eruption ensues it should be discontinued until the excessive hyperæmia disappears.

The potencies which have served me the best have been the third and 30x; possibly it might be used higher. I have tried it when everything else has failed me and the proportion of cures has been beyond my most sanguine expectations. I have often substituted it for a potency of sulphur and then returned to thyroidine with excellent results.

It is not my intention to overestimate any particular remedy, but I think my experience will warrant a trial of the plan I suggest. To me there is a satisfactory explanation in the comparative metabolism which I have tried to outline in the symptoms above. I trust that I may find further confirmation from the profession at large.

Discussion: Dr. Taylor: I have listened to Dr. Halbert's paper with a great deal of interest and regret exceedingly that I am not able to discuss it as it justly deserves. Dr. Halbert's recognized familiarity with the great nervous system that governs the economy of man has been splendidly utilized in his exposition of the very obscure etiological factor which enters into this troublesome cutaneous lesion. This disease, which neither aggravates nor is aggravated by other morbid conditions, is an enigma to the profession, and I think I make no mistake when I say it has in most cases baffled the skill of the specialist. Dr. Halbert's paper will prove a long step in the right direction, and the gleam of light he has let in will, I believe, be a benefit to us all. I have thought that the lesion was caused, not from a diseased nerve centre, but from some atonic condition of the periphery and have used silicea with some little success.

Dr. Halbert: I do not wish any one to understand that I claim thyroidine to be a "cure-all" in every case of psoriasis. I have simply referred to my experience in several cases where other remedies failed. I desire also to

call your attention to the fact that I do not believe in "thyroid-feeding." My claim is that it will work better in potency, and this I have proven to my own satisfaction. There is great danger of aggravation from the excessive use and this is my reason for the use of the potency. I only wish that you try it as I suggest.

The aim of my paper has been to show the pathological and symptomological relation of psoriasis and myxœdema, that we may give some attention to the thyroid condition in both cases.

VOLUNTEER PAPERS. X. RETINAL DETACHMENT; REPORT OF A CASE. BY DR. C. J. SWAN. — *Case.* Mrs. McCabe, æt. sixty, farmer's wife, residing in central Illinois, active and well able to perform the duties of her position without undue fatigue. A history of a lifetime of perfect health and no hint of a suspicious heredity could be obtained. The patient testified that the left eye had been weak for several years, but that the right eye was perfectly good and strong until about one week previous to the examination an apple had fallen upon it, since when vision had diminished, although at no time had there been pain or inflammation in the eye.

The right eye, the one recently injured, was examined first. Externally it appeared perfectly sound and free from disease; tension slightly diminished, refraction normal. Vision about one half of normal; cornea and lens clear; many floating opacities in the vitreous showing a past inflammation of the vitreous or its hyaloid membrane; retina congested and looking extremely irritable without being positively inflamed.

In the left eye vision was much impaired, being reduced to an ability to count figures at a distance of six feet. Partial opacity of the lens; high myopia with posterior staphyloma and the vitreous filled with floating opacities. This organ of sight was, as can easily be seen, in a generally diseased condition and beyond reasonable hope of aid.

The right eye, however, in which vision was said to be satisfactory up to the time of the accident, I believed could be helped by giving it absolute rest. To that end I ordered atropine grs. iv. to the ℥i t. i. d. dropped into the conjunctival sac, dark glasses and internally, kali. iod.

With this line of treatment the patient returned to her home in the country with instructions to report in two weeks. November 2, 1896. Reports vision not improved. Ophthalmoscope showed, in addition to previous conditions, a *retinal detachment* in the highest part of the globe and occupying a space about twice the size of the end of a lead pencil and hanging like a miniature satin canopy from the vault of the eyeball. I explained the gravity of the condition and urged the patient to enter the hospital at once for treatment. Mrs. McC. however deeming it necessary to return home before confining herself to a hospital, left the city and came back five days later. Vision was now further reduced and the detachment occupied a space corresponding to one-fourth of the entire inner surface of the globe.

She was taken to the Hahnemann Hospital, placed in bed and instructed to maintain the supine position. Cocaine and atropine were instilled thrice daily, a pressure bandage applied, medicines given which were calculated to keep the excretory functions of the bowels and skin active and a liquid diet ordered.

The second day I punctured the globe in the region corresponding to the detachment, thus allowing the subretinal fluid to escape, and reapplied the pressure bandage.

The reaction after the operation was severe, the whole eye becoming inflamed and the patient suffering a good deal of pain therefrom for about forty-eight hours. Hot compresses, with the cocaine and atropine, finally relieved the pain and at the end of the third day the eye was sufficiently quiet to permit of ophthalmoscopic examination. I was well satisfied when I found the area occupied by the detachment was reduced one-half. If I could but maintain this improved condition until such time as the eye should become sufficiently quiet for a second similar operation I might hope for a comparatively successful issue. Unfortunately this was not to be. The clearing up of the eye occupied ten days, at the end of which time I saw that the detached portion had regained all the lost ground and more. At least one-third of the retina was now separated from the choroid. The case was indeed hopeless and I sent the unfortunate woman home at once lest she become blind before leaving the hospital.

Many methods of treatment have been suggested and experimented with in cases of detached retina. Attempts

have been made to *stitch* the retina into place. Irritants have been injected between the retina and choroid for the purpose of setting up enough inflammation to cause adhesion between the retina and choroid. This procedure has always been successful in exciting the inflammation but to such a degree as to destroy the eye. It has however long been agreed that rest in bed upon the back is essential in all forms of treatment. The method used in the above case is the only one that has ever met with any degree of success, and then in but a very limited number of cases. When the detachment is the result alone of a blow upon the eye and there are no other diseased or injured parts of the eye, this method may be used with more than a faint hope of success. I believe that a fact not generally known even among excellent anatomists is that the retina *lies in contact* with the choroid and is not attached to it at any place except at its extreme periphery at the ora serata, and at the entrance of the optic nerve into the eyeball. The retina is held in its place in close contact with the choroid by the pressure of the vitreous body as I have been able to demonstrate in my own experiments in mounting eye specimens. Thus it will be seen that anything which might interfere with the nutrition of the vitreous body would probably cause it to shrink and thus allow the retina to slip away from its place. In the eye which I treated there had been disease of the vitreous before the injury, the former acting as a predisposing cause and the latter as an exciting cause of the detachment, or a better word would be "displacement" of the retina. When there has been actual shrinkage of the vitreous the prognosis is absolutely bad. Occasionally it may be possible to replace the retina, and it may remain in place for a time, but before a year is passed it will again become displaced and the fluid which is between it and the choroid will spread itself around until the entire retina is detached. Detached retina is recognized as such by loss of transparency at the point of detachment. Instead of the red reflex we have a dead white or a sheeny white satin like projection in the

fundus and an undulatory movement of the membrane, over which are seen running the retinal vessels from their source in the optic nerve.

Exhibition of Morbid Specimens.—By request of Dr. Shears, who was unable to be present, Dr. Haseltine presented three morbid specimens for the consideration of the society. The first was a sequestrum from the arm of a five-year-old boy, the operation having been made ten days previous in the presence of the senior class. The second was a carcinoma of the tongue from a case in which the Whitehead operation of removal of one-half of the organ had been performed. A detailed report of these two cases may be found at pages 72 and 78. A third specimen was presented consisting of a tumor of the testicle, removed only a few hours before from a patient fifty-four years of age. The growth presented somewhat the appearance of a sarcoma, but owing to a specific element in the history of the case there was some doubt as to the diagnosis. The complete history will be published later.

Death of Dr. W. H. Burt.—Dr. Ludlam notified the society of the sudden illness and death of Dr. Burt, one of its oldest members, and paid a brief tribute to his merits, especial emphasis being placed upon his long-continued labor and his publications in the line of the materia medica.

SENIOR PROFESSOR OF SURGERY AND SECRETARY OF THE BOARD OF TRUSTEES OF THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO.

Editorial.

THE TWENTIETH ANNIVERSARY OF THE CLINICAL SOCIETY.—In honor of this event the governing faculty of the Hahnemann Medical College and Hospital of Chicago, gave a dinner to its auxiliary faculty at the Union League Club on the evening of February 6. Dean Vilas, presided, and twenty-five professors and lecturers took seats at the round table. Three of the original members were present: Drs. Vilas, Bailey and Ludlam. Many interesting facts connected with the development and the busy, fruitful career of the society were recalled and recited, and mutual congratulations were in order.

This society, which, as was happily said, had a good stamp and a good start in 1877, has missed only *two* of its monthly meetings in twenty years; and has not accepted or published a single controversial paper, but has devoted itself exclusively to clinical work, that is founded on observation and not on reasoning, in the various departments of medicine and surgery. Its president, Prof. Shears, spoke very earnestly of its claims to the support of the profession both in and out of the college, and of what it was capable of doing without any overstrained expectations in the next twenty years. Prof. Ludlam, who had sifted a few reminiscences for the company, spoke of its inception at a conference between Drs. Smith, Small, Hall and himself held in Philadelphia in July, 1876, paid a passing tribute to their zeal for the welfare of the "Old Hahnemann," and closed by saying that, after all it is not so much what the founders of this society attempted as what its friends have accomplished that interests us now.

Eloquent and inspiring speeches were made by several others, but we have space only for a few extracts from Prof. Bailey's remarks on

Homœopathy — Protestantism in Medicine. "It is a fine thing to

ripen without shriveling; to reach the calmness of age; yet keep the warm heart and ready sympathy of youth."

This is as desirable in social organizations as in individuals. The warm heart for progress and improvement and the ardor of youth in the pursuit. It seems to me that our clinical society is in splendid growth at its birthday party. There is not a wrinkle like shriveling nor a feature that is not fair.

I was fortunate in being in the audience at the first public session of that society. I remember that I thought the session was a wonderfully smooth meeting. There were several announcements that impressed me. It was said that a new era in medicine was coming. After discussion the society agreed to support the clinical idea in medicine It announced its creed and I know that for the twenty years the members have kept the faith.

Froude says "The practical effect of a belief is the real test of its soundness." The text of the new creed was the elaboration of the methods to be used and all agreed that clinical experiences were to be carefully prepared and related, and that medical essays and personal tributes, were to be relegated. For years I scarcely missed a meeting of the society, and I can say that I have never known any departure from the strict spirit of its incorporation. The practical effect of the organization has proved the soundness of the proposition of twenty years ago.

In a way this society was a sort of protest. In those days I learned that a political ferment was often present in medical meetings, and that the better part of the work was slighted in the interests of transitory things. I cannot recall a single instance where a moment has been lost in medical politics by this society; and its published transactions will show that each successive year it has been well officered and progressively conducted.

Speaking of protests, I should like, if I had the time and the occasion were different, to elaborate the idea that homœopathy came into existence as a protest against the medical usages of its time. There is a sort of parallelism that is very close in the history of the doings of the two occupations, the clergy and the doctors. Homœopathy is protestantism in medicine. There was a fierce struggle at the time of the reformation; Martin Luther offered protest after protest against certain dual usages of the church, one secular and the other spiritual, and after the warfare of nearly twenty years the Emperor made a final effort to crush the reformers and to blot out the spirit of reform Said he "Summon the protesting princes and bid them withdraw their protest" This was in 1530, and the name was then given to a sect, protestants They made vigorous protests against the usurpation of secular and spiritual powers of the church, and the number of protestants now constitute about 8 per cent of the religions of the world.

The medical reformation of Hahnemann had in it many of the parallel experiences of Luther. Martin Luther did not complain that all the things pertaining to the Church of Rome were wrong, abuses had arisen. Hahnemann did not attack the whole system of medicine, he found abuses. He protested, (and it seems a bit of human nature to meet a protest with abuse). I do not believe that as Hahnemann emerged from the reformation he inaugurated that he thought he had founded a perfect system of medicine, one that would know no progress, no improvement. I hope for immediate excommunication if it be that the present status of our profession is the highest it shall ever obtain. I venture the proposition that the protestant doctors, if you will allow me, do not average more in per centage in the world of medicine than do the protestants in the church world. Yet no protestant speaks dispairingly of his church, neither should we of our numbers.

Now prejudice is more of a crime than ignorance. The very first fruits of protestantism begat a race of fanatics and pseudo-reformers who went wild with their freedom from both secular and spiritual restraint, and well-nigh lost the vantage gained. They followed to the full their prejudices, they were still in ignorarce. What happened just after Hahnemann offered his protests and announced his *similia similibus curantur?*

"That is a good book which is opened with expectations and closed with profit." The successive volumes of transactions of this society—three years of transactions being incorporated in the *U. S. Medical Investigator* and the seventeen years of faithful records in the CLINIQUE, all real witnesses, that the published work of the society, which was opened with expectations has been closed up to date with profit. Not once has there been any page that reflected prejudice nor exhibited ignorance. Jealousy is an indication of inferiority, and as a protesting body of medical practitioners there never has been a day since the medical reformation when our system had any occasion to feel jealous. Empiricism still holds the mortgage on medical practitioners, but our clinical observations, based on provings, are the gilt-edged securities of our business.

Linked as a society to a great educational, medical and clinical centre our opportunities are enormous, our responsibility correspondingly great. Should yet another twenty years of active service be granted us it would seem wise for us to be still observing, recording, patiently, persistently, courageously protesting against abuses, and as warmly welcoming truth, however presented. The red cross of the international brotherhood is our outward decoration and the heart responds to the sentiment of the autocrat:

"Health to the art whose glory is to give the crowning boon that makes it life to live."

LITERARY AND EXPERIMENTAL RESEARCH IN MEDICINE.—In Dr. Conrad Wesselhoeft's address, which was not a

still-born affair, there is a passage that is of the greatest significance: "What Hahneman endeavored to do by years of *literary* research and profound thought, now at length deserves to be corroborated by modern methods of inductive *experimental research.*" In other words, it has occurred to our friend that the day for depending exclusively upon the "inner consciousness" and the old tenets as guides to the nature of the disease, the choice of the remedy and the claim for success in therapeutics has passed, or is fast passing away.

Of the general truth of this proposition there can be little doubt. The difficulty is so to adjust our clinical methods to the new state of things as to bring order out of chaos, and to lift Homœopathy into the realm of the applied sciences. Its literary, contentions and experimental stage was a stepping-stone upon which its followers, however loyal and zealous, cannot always be expected to stand and to be content. We should progress, and there is room for improvement; but we must hasten slowly, or the real claims of our method of cure will always be surrounded by an atmosphere of unveracity.

POST-GRADUATE WORK IN LONDON.—As will be seen in our advertising pages, the medical and surgical staff of the London Homœopathic Hospital has arranged for an excellent course of post-graduate instruction therein during the months of May, June and July, 1897. The clinical scheme is enterprising and in every way fit and timely. Nothing can give a better idea of the earnestness of our good brethren over there than their willingness to turn the resources of that noble charity to good account for the benefit of the general profession. And whoever among our qualified physicians goes to London this spring should certainly avail himself, or herself, of this new and peculiar privilege. Theoretical lectures are like "medicated novels;" but the clinical, objective work that such men as those London doctors will do, will please and endure, for it will avoid what has been styled "the process of death by explanation." We shall hope for a good report from this most commendable undertaking.

Hospital Notes.

THE CLINIC ON NERVOUS DISEASES.

SERVICE OF PROF. O. L. SMITH.

Reported by I. O. Denman, M. S.

Neurasthenia with prominent ocular symptoms.—*Case 16,222.* Miss M. W., æt. twenty-six. She was the weaker one of twins, always left in the house, being unable to participate in the usual sports and games of childhood. For no known reason, except at the age of ten years she was much reduced, ptosis and slight strabismus of the left eye developed, for the relief of the former condition she has undergone three operations with but slight, if any relief. She does not know how long the slight dilatation of the left pupil has existed. Has been annoyed all her lifetime with inappetency, constipation, insomnia, "nervousness," cold hands and feet, and weakness. Is now much discouraged and irritable, dreads and magnifies, and always has, any responsibility or duty.

It enlists no especial perspicacity to read between the lines that this girl has alternated between physician and oculist, each, after a partial and consequently unsuccessful trial, believing the case to reside in the other's realm, she thereby failing to receive the necessary care at a most impressible time. Then is it any wonder that invalidism —not to mention impending bachelorhood—sends us a thoroughly disheartened and discouraged patient? Let us see if we cannot untangle this case. The freshman declares the lesion central—a brain tumor; the sophomore "passes;" the junior blames "early symptoms of locomotor ataxia;" but let us take the advice of a senior, who suggests that we examine further.

The strabismus is convergent, implicating but the left eye, and not due to any paresis of the external rectus, as you see; the glasses confirming her statement that she is hypermetropic. There are no irregularities or attach-

ments of the margin of the iris, indicative of an ancient iritis, or enlarged cervical, bronchial or unilaterally developed thyroid glands that would determine the pupillary dilatation. Now let us see if it is possible to place a lesion that will account for these three ocular symptoms. You will readily grant that it must be of unilateral origin, involving either the cervical sympathetic, the third nerve or its nucleus. Simply because we have ascertained no irritation along the cervical sympathetic is not proof positive that such does not exist; yet the fact that a lesion so placed will not occasion the strabismus would alone confirm the result of the examination; but additional proof is afforded in the fact that the eye opens normally, thus excluding the participation of the sympathetic fibres in the production of the ptosis.

Since these three symptoms demand that some of each of the three sets of fibres of the third nerve be involved, it matters not whether the lesion be placed along the trunk or at the nucleus of the nerve, which latter is found on either side of the median line in the floor of the aqueduct of Sylvius. A tumor involving the nucleus would have long since occasioned pupillary dilatation, *complete* ptosis, *external* strabismus and inability to move the eye inward, upward, or downward. Moreover the pressure upon the superimposed corpora quadragemina would have produced visual disturbance, incoördination of movement, etc. The ophthalmoscope reveals no abnormality of vessels or nerves in either eye. There is no ocular protrusion, the motions are preserved and the pupils dilate upon cervical stimulation. She can talk, swallow, hear, taste, smell, wrinkle the forehead and pucker the lips as well as you or I. There are no anæsthetic spots upon the face or body and both superficial and deep reflexes remain intact. There is neither static nor locomotive ataxia. Enjoin the lack of persistent headache and cerebral vomiting, and the long existence and non-progression of the symptoms, when we have excluded every possibility of the existence of a tumor. While the presence of such ocular symptoms not

infrequently presage the development of locomotor ataxia, yet a knowledge of the lack of the following points, usually in possession of a neurologist renders the cognizance of their true significance less difficult for him than for the oculist. The case is not one of tabes, for there is present no static or locomotive ataxia and she can go about nights, up and down stairs, over rough ground, walk a crack, backward or blindfolded as well as any one, stopping and starting instantly. She has neither fulgurating pains nor sphincteric involvement; the knee reflex is preserved and the pupils react to light and distance, thus proving our assertion and finally establishing, through the unharmonious and inconsistent nature of the symptoms, the functional nature of the derangement.

Considering the case clinically, and as it first impressed us, we find that, 1. This girl is the weaker exponent of a twin birth, always a weakling, anæmic, unable for and disliking —heightened because much given to books—fresh air and out of door exercises. 2. She has always been far sighted.

What else could we anticipate but that this handicapped, illy-nourished, hypermetropic girl of introspective habit—and consequently increasingly hypersensitive, of solitude, books and pain would become neurasthenic? The efforts required to properly focus during reading or needlework, effected an overaction of the internal rectus, destroying the muscular balance and determining internal strabismus, all the more easily brought about by the underlying and characteristic weakness and irritability.

And as to the two remaining symptoms it not infrequently happens that such patients have pupillary inequality and unilateral ptosis, and the more readily so in this case because of the neural depletion consequent upon the refractive error, she concurring positively in our assertion that her three symptoms are invariably worse whenever she is tired or menstruating.

"Hind sight"—which is declared better than foresight —aside, the treatment now is self-evident and it is: 1, hypernutrition; 2, anabolic stimulation; 3, lessening of peripheral ocular irritation.

While we can scarcely hope for a complete recovery from both local and general symptoms, yet I am inclined to prognosticate considerable improvement even of the eye symptoms. When she arrives at her best physical condition will be time enough to consider operative influence. Operative correction of the strabismus prior to proper refractive and nutritional effection would prove most unfortunate for upon the resumption of health the oculist would be called upon to undo his work.

The brief study of this case argues the importance of 1, an *attentive* decision between conditions organic and functional; 2, a careful analysis of general and local symptoms, their relation and the underlying and exciting cause; 3, an early correction of refractive errors; 4, operative influence when general health much improved.

January 26, one month later. This young woman reports much general improvement and says that her family has noticed and voluntarily spoken of an improvement of both the strabismus and ptosis, which with the equality of the pupils is confirmed by senior students here and those who saw the case initially, although she is "tired to-day and not as well as usual."

Psychic epilepsy.—*Case 16,216.* Peter R., German, æt. twenty-nine. Has always been well until present illness, disclaiming any transmitted or acquired specific taint. His mother had epilepsy, but experienced a cure which for many years has proved permanent. Otherwise, the family history negative. During the year 1892 he was employed as a night watchman in a large factory: and being a non-union man, and returning home at three o'clock in the morning, was in constant fear of bodily harm. For almost three years subsequent to this he was employed in the Pullman shops, working eight hours a day with hands and arms immersed in turpentine, benzine and oil. This was discontinued in May of '95, and during the following October his family occasionally noticed that when spoken to he would remain staring for a very short period of time, not hearing, or at best returning a little later an entirely foreign answer.

He soon began having attacks lasting from fifteen minutes to two or three hours "when he is not himself,

becoming vicious and pugnacious, failing to recognize and turning against his best friends, finally regaining his normal condition wholly unaware of what had transpired." Some months ago he began having typical attacks of the confirmed variety of epilepsy, or grand mal, once or twice a week. He was accepted conditionally, given hydrocyanic acid 6x, put on an almost exclusive milk diet, and under constant guard. He improved decidedly for two weeks. The report at the end of the third week was very bad, and indeed he had a short attack in the clinic, initiated by his unbuttoning his clothes and marching out of the room muttering. He was brought in again and made to take his place with some difficulty. He was finally discharged, and it was advised that he be sent to an asylum for the care of the insane.

This case presents an interesting grouping of symptoms; in one instance giving petit mal, in a second grand mal, and in a third intermittent epileptic insanity or psychic epilepsy. The prognosis is, of course, very unfavorable. Cognizant of the reflex character of both the physical and the mental epileptic phenomena, we must know that such men are wholly irresponsible for acts committed during this unconscious cerebration; for we know that in the midst of their mental confusion memory calls up painful past impressions resulting in instantaneous, sudden acts of violence, hours, sometimes days, thereafter, regaining consciousness without any recollection of the happenings, or at least only a very confused, bewildered idea of what has transpired. These unfortunates are most dangerous irresponsibles, and the public should be most carefully protected from their misdeeds.

Clinical Reviews.

All books for review, magazines, exchanges, correspondence and articles designed for publication in this journal should henceforth be sent to Dr. R. Ludlam, editor, 1823 Michigan Avenue, Chicago.

A MANUAL OF PHARMACOLOGY AND THERAPEUTICS. By WILLIAM MURRELL, M. D., F. R. C. P., Physician and Lecturer at the Westminster Hospital, etc., etc. Revised by FREDERICK A. CASTLE, M. D., Member of the Committee for revision and publication of the Pharmacopœia of the United States of America, etc., etc. New York. Wm. Wood & Co., 1896. 8 vo. pp. 516.

The arrangement of this work is excellent. The Introduction treats of Ancient remedies, Sources of medicines, Adulteration of drugs, Pharmacological investigation, Idiosyncrasy, Tolerance and habit, Accumulation, Incompatibility, Antagonism, and all kinds of Accessory Treatment; Part II., the Pharmacology of Inorganic substances; III., the Pharmacology of Synthetical compounds, as sulphonal, amyl nitrite, nitroglycerine, phenacetine, etc.; IV., the Pharmacology of Drugs of Vegetable origin, and V., the Pharmacology of Drugs of Animal origin. The text is terse and exceedingly practical, and whatever we may want to know of this or that remedy is available in a moment. We commend the book as the very best of its kind.

VETERINARY HOMŒOPATHY IN ITS APPLICATION TO THE HORSE; INCLUDING A CODE OF COMMON SUGGESTIVE SYMPTOMS. By JOHN SUTCLIFF HURNDALL, Member of the Royal College of Veterinary Surgeons, England. Philadelphia: Boericke & Tafel, 1896. Large 8 vo. pp. 343.

A book that carefully treats of the common and oft-repeated ailments of his best friend should be available to every doctor who does not creep around on foot, or commit himself to the tender mercies of the wheel on the way to his patients. Briefly this is the most thoroughly clinical veterinary work that we have ever seen, and considering how very much can be done for sick horses, as well as for other animals, by a proper application of the homœopathic principle, it is really a most useful publication.

Written in a plain and simple style it is suited for the layman as well as for the doctor, and it merits a large sale. Its "code of common suggestive symptoms" would put almost anybody on the right diagnostic scent, while its pathology and therapeutics are almost perfect.

ANATOMICAL ATLAS OF OBSTETRIC DIAGNOSIS AND TREATMENT. By OSCAR SCHAEFFER, M. D. with 145 illustrations. New York: Wm. Wood & Co., 1896.

This beautifully illustrated volume deals with the morphology of the female pelvic organs as the anatomical basis of the physiology and the pathology of pregnancy and labor. The diagnostic points and indications for treatment that are deducible from these data are so plainly set forth that the book is clinical as well as elementary and scientific. It will therefore prove not quite as useful as any other atlas in the series that has lately been issued by the same enterprising publishers.

REPERTORY OF TONGUE SYMPTOMS. Arranged by M. E. DOUGLASS, M. D., Baltimore, Md. Philadelphia: Boericke & Tafel, 1896.

The clinical necessity for a careful study of the tongue, objectively of course, is conceded; but the examination of it as indicating in the choice of a remedy has been very much neglected. This little book tells its own story without note or comment, Part I. being a Repertory of Tongue symptoms; II., a Repertory of Mouth and Tongue symptoms in Typhoid Fever; and III., Remedies. It seems to have been very carefully compiled.

THE MEDICAL AND SURGICAL USES OF ELECTRICITY. By A. D. ROCKWELL, A. M., M. D., etc., etc. Illustrated with 200 engravings. New Edition. New York: Wm. Wood & Co., 1896.

This, which is practically the ninth edition of Beard & Rockwell's treatise on the same interesting subject, is, however, a new and up-to-date treatise. Its author has of necessity shown a very progressive spirit in displacing much of the old rubbish and machinery of the early period, and the consequence is in every way desirable and praiseworthy. The pages are closely printed and are so packed, not padded, as to furnish a full book on the medical and surgical uses of Electricity.

Miscellaneous Items.

The Final Examinations in the Old Hahnemann begin March 12.——The Alumni meeting occurs March 24; the Commencement March 25.——The Rev. Dr. Crane will deliver the Valedictory.——A grand concert will be given under the auspices of the Federation of Ladies' Circles at Steinway Hall on the evening of February 25, for the benefit of the Hahnemann Hospital.——Our list of removals includes that of Drs. I. L. Peebles, from Meriden to Hattiesburgh, Miss.; S. E. Boulter, from Correctionville to Des Moines, Iowa; Catharine Walker, from Rochester, N. Y., to Titusville, Pa.; S. Staads, from Pomeroy to Sioux City, Iowa; A. S. Eshbaugh, from Chicago to Kankakee, Ill.; J. E. Shearer, from Clearmount to Marysville, Mo.; E. G. Bergeron to 1209 Champlain Building, city; C. F. Mitchell from Minneapolis to Good Thunder, Minn.; D. B. Hall from Urbana to West Liberty, Ohio; D. De Forest Cole from Albion to Batavia, N. Y.; W. C. Wight from Dawson to Dunlap, Iowa; J. D. Hudden from Woodlawn Avenue to West Pullman, Ill.; H. Tyler Wilcox to 2924 Washington Avenue, St. Louis; and J. A. Knox from Stuart to Adair, Iowa.——Dr. A. C. Croftan has a downtown office at 103 State Street.——Prof. C. S. Mack has settled for practice at La Porte, Ind.——We sincerely regret the death of our old and tried friend, Dr. T. J. Patchen, of Fond du Lac, Wis., in his seventy-ninth year.——Dr. Burt's death is noticed at page 102.——Prof. Crawford will give a popular address at the meeting of the Colorado Society in May next.——The Section on the Surgical Diseases of Women will report at the next meeting of the Clinical Society, February 27.——The transactions of the International Homœopathic Congress, London, are received as we go to press; do. those also of the fifty-second annual session of the American Institute of Homœopathy.——Dr. Taylor's paper at page 81 is sure to attract the attention of our readers, and so is that of Dr. Halbert at page 95.——The many good things that are being said and written of the CLINIQUE are fully appreciated at headquarters.